The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
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# Department of Public Health
# Bureau of Substance Abuse Services
# Complaint Form

**Section I- Complainant Information, the person or place filing the complaint**

Please provide your name and/or the name of the substance abuse treatment program making the complaint in the appropriate spaces below, or:

I wish to file an anonymous complaint with the Bureau of Substance Abuse Services ❑ yes ❑ no
If yes is checked please skip to section II

1. Complainant Name:

First Last

2. Address:

Number Street Daytime Phone

City State Zip Code Evening Phone

3. Program Name:

Number Street Business Phone

City State Zip Code Business Fax

4. Program Contact Person:

5. Best way to reach you: Daytime Phone ❑ Evening Phone ❑ or Email:

**Section II - Licensee Information, the person or place the complaint is being filed against**

6. Licensee Name:

_____

7. Licensee Location, if known:

_____

8. Briefly describe the incidents that led to your complaint and note the times and dates that events occurred. List the names of all individuals involved. You may respond to the questions below or attach your own narrative describing the event. Please attach additional pages if needed.

A. What are the details of the incident:

_____

_____

B. When did the incident take place:

_____

C. Where did the incident take place:

_____

D. Was anyone else present at the time of the incident, if yes, please provide there name(s) and contact information:

_____

_____

E. Please describe the impact of the incident:

_____

9**. Additional information or materials attached** __ **Yes** __ **No**
To speed up processing your complaint, please submit legible copies (not the originals) of all relative documents supporting your complaint (i.e. contracts, medical records, cancelled checks, etc.). You will receive an acknowledge letter indicating we have received your complaint.

10. **Section IV Authorization**
Providing your authorization will help the Bureau of Substance Abuse Services investigate your complaint. It is not required if you are filing a complaint anonymously.

My signature to this form or a photocopy thereof, authorizes the Department of Public Health to:

(1) To investigate my complaint
(2) To receive copies of all substance abuse, medical and mental health records relating to my complaint

I attest that the information provided is true, correct and complete to the best of my knowledge.

_____

Complainant Signature Date